Date: ……/……/……...

Name: ……... DOB: ……

Address: ……..

…….. Phone no. …….

Medical History: do you, or have you, suffered any of these?

- ☐ Asthma
- ☐ Angina
- ☐ Back pain
- ☐ Blood Pressure, High
- ☐ Blood Pressure, Low
- ☐ Broken bones
- ☐ Diabetes
- ☐ Hayfever
- ☐ Headaches
- ☐ Hospitalisation
- ☐ Migraines
- ☐ Operations
- ☐ Sleep disorder
- ☐ Thyroid, overactive
- ☐ Thyroid, underactive

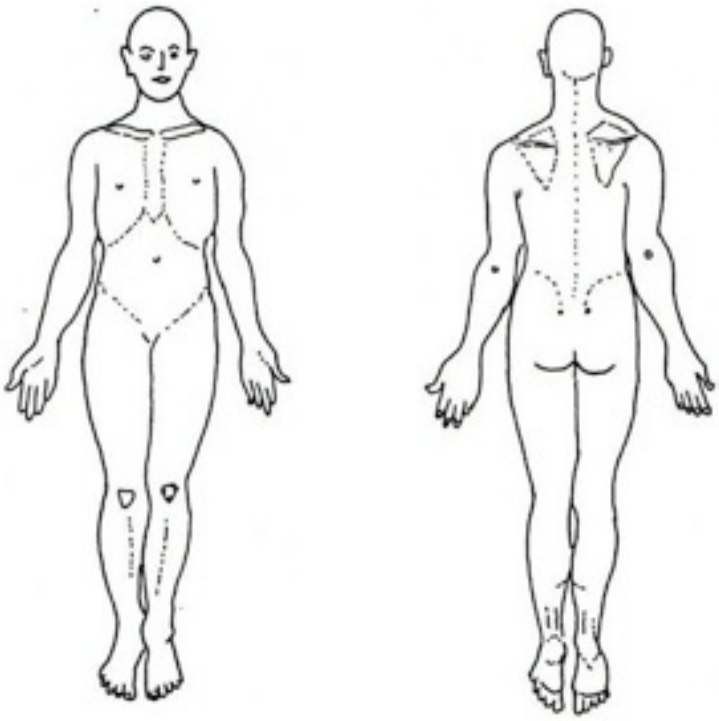
Anything else:

Medication - prescribed:

Medication/supplements - non-prescribed:

Main complaint:

Please indicate location & severity of symptom/10



What makes symptom worse?

What reduces symptom?

Sleep:

Energy:

Treatment/s tried so far for main complaint.

Treatment plan agreed:

I agree the above information is correct and choose treatment /have agreed treatment plan as above.